CMAW BENEFIT PLAN

REVISED CARD – CHECK HERE ❑

APPLICATION FOR ENROLMENT AND BENEFICIARY DESIGNATION
Please complete in ink and print clearly. This is a two-sided form – please see reverse.
Please fill in all information and ensure you have signed and dated this form.
NOTE: This form is for the Health Plan ONLY and will not update your beneficiary on your Pension Plan.

MEMBER INFORMATION

NAME (Surname, Given Name & Initials)			SOCIAL INSURANCE NUMBER
ADDRESS (No. and Street)	CITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER	GENDER (Male/Female)	DATE OF BIRTH (Month, Day, Year)	TRADE
PHARMACARE REGISTRATION NO. (where applicable)		EMAIL ADDRESS	

MARITAL STATUS DECLARATION – Refer to other side for the definition of an eligible Spouse

I hereby certify that I have read the Spousal Definition and that, as of the date of this declaration, I have a Spouse as follows:

SPOUSE'S NAME (Surname, Given Name & Initials)	GENDER (Male/Female)	DATE OF BIRTH (Month, Day, Year)	DATE OF MARRIAGE, OR DATE OF COMMENCEMENT OF COMMON-LAW RELATIONSHIP:

DEPENDENT INFORMATION (Other than Spouse) – List all eligible dependents, other than your Spouse, starting with the eldest: If adding children over 19, indicate the school they are attending full-time.

NAME (Surname, Given Name& Initials)	RELATIONSHIP (Son/Daughter)	DATE OF BIRTH (Month, Day, year)	STUDENT (Yes/No) and name of school, if over 19

CO-ORDINATION OF BENEFITS

Are you covered by another benefit plan (ie you Spouse's Plan)? ❑ Yes ❑ No If YES, indicate the benefits covered: _____ Policy No(s)_____ Insurance Carrier_____

GROUP LIFE INSURANCE BENEFICIARY DESIGNATION

I designate the following individual(s)* as my revocable group life insurance beneficiary(ies), if living, otherwise my Estate* and revoke any prior designation I have made. *Indicate Estate, if no named beneficiary.

NAME (Surname, First Name & Initials)	RELATIONSHIP	
		%
		%

APPLICATION FOR ENROLMENT

I, the undersigned, hereby:

a) apply to be enrolled as a Member of the CMAW Benefit Plan,
b) certify that the information provided on this form is correct,
c) consent to the collection, use and disclosure of my personal information by the Board of Trustees of the Plan (or its authorized agent) for the purpose of administering the Plan and the benefits that may be conferred on Members of the Plan,
d) agree to be bound by all the terms and conditions of the Plan,
e) **agree to promptly update the Plan Administrator on any changes to the status of a Spouse, dependent or other beneficiary, and**
f) agree that I am liable for any benefit paid out incorrectly in the event that I have not updated the Plan Administrator on any change to the status of a Spouse, dependent or other beneficiary
g) understand that completion of this form does not in itself, entitle a Member to benefits – qualification for benefits is in accordance with the rules of the Plan
h) **certify that I have read the information provided on the reverse side of this form.**

_____ _____
SIGNATURE OF MEMBER DATE

SPOUSAL DEFINITION – if you are indicating a Spouse on the reverse side (page 1), under MARTIAL STATUS DECLARATION, they must meet the following definition:

The CMAW Benefit Plan defines "Spouse" as:

"The legal spouse of the Employee, or, in the absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person with whom the Employee has been living and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time".

Common-law spouses must meet the Plan's minimum co-habitation rule.

COMMON-LAW DEPENDENTS

*Common-law spouses and their children **may be** eligible with a minimum cohabitation period as indicated in your group policy. NOTE: Only the children of your common-law spouse who are residing with you are considered eligible dependents.*

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The collection, use and disclosure of an individual's personal information by the Board of Trustees of the Plan (or the Trustee's authorized agent) during his/her participation in the Plan is for the purpose of administering the Plan and the benefits that are conferred on Members of the Plan. The collection, use and disclosure of personal information about individual Members of the Plan will be done in a manner that is reasonable. Furthermore, reasonable security arrangements will be taken to prevent any unauthorized access, collection, use, disclosure, copying, modification or disposal of personal information about individual Members of the Plan.

cbp
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PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATOR:

BILSLAND GRIFFITH BENEFIT ADMINISTRATORS
1000-4445 Lougheed Hwy
Burnaby BC V5C 0E4
Toll-Free: 1.844.366.2629
Fax: 604.433.8894
CMAW@bgbenefitsadmin.com